EHDI
Iowa's Early Hearing Detection & Intervention Program

Early Hearing Detection and Intervention
Diagnostic Reporting

Site:	**Assessment Date:**

Patient Name (Last, First, MI):	**Medical Record Number:**

Child Demographics:	**Risk Factors**	
Date of Birth:	☐ None	☐ NICU > 5 Days
Place of Birth:	☐ Congenital infection	☐ Craniofacial anomalies
	☐ Family history of hearing loss	☐ Ototoxic meds

Mother / Guardian Information:

Name (Last, First, MI): _____

Address: _____

Phone: _____

Test Results:

Behavioral Method: VRA   CPA   Conventional   **Type of Loss**: (normal, conductive, sensorineural, mixed)
(circle one)   Right _____   Left _____

Frequency	250	500	750	1000	1500	2000	3000	4000	6000	8000
Right										
Left										
Sound Field										

Speech Detection / Speech Recognition Threshold
(circle one)

Right	
Left	
Sound Field	

Tympanometry   226 Hz / 1000 Hz
(circle frequency)

Ear	Type	Classify based on
Right		shape
Left		(A, B, C, A_D, A_S)

Auditory Brainstem Response /
Auditory Steady State Response (circle one)
Results:

Otoacoustic Emission   DPOAE / TEOAE
(circle one)

Ear	Result	
Right		Classify based on
Left		*Pass / Refer*

Intervention Dates:

Hearing loss confirmation _____   Decision to aid _____

Last Assessment _____   Fitting _____

Device Data:

Comments / Recommendations:

Assessment Performed By:	
Child's Primary Care Provider:	